TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Interim Joint Commission on Health Services

Lisa Lee, DMS Commissioner
Steve Bechtel, DMS Chief Financial Officer
Veronica Judy-Cecil, Sr. Deputy Commissioner
Dr. Leslie Hoffmann, Deputy Commissioner

November 18, 2024

ORGANIZATIONAL STRUCTURE

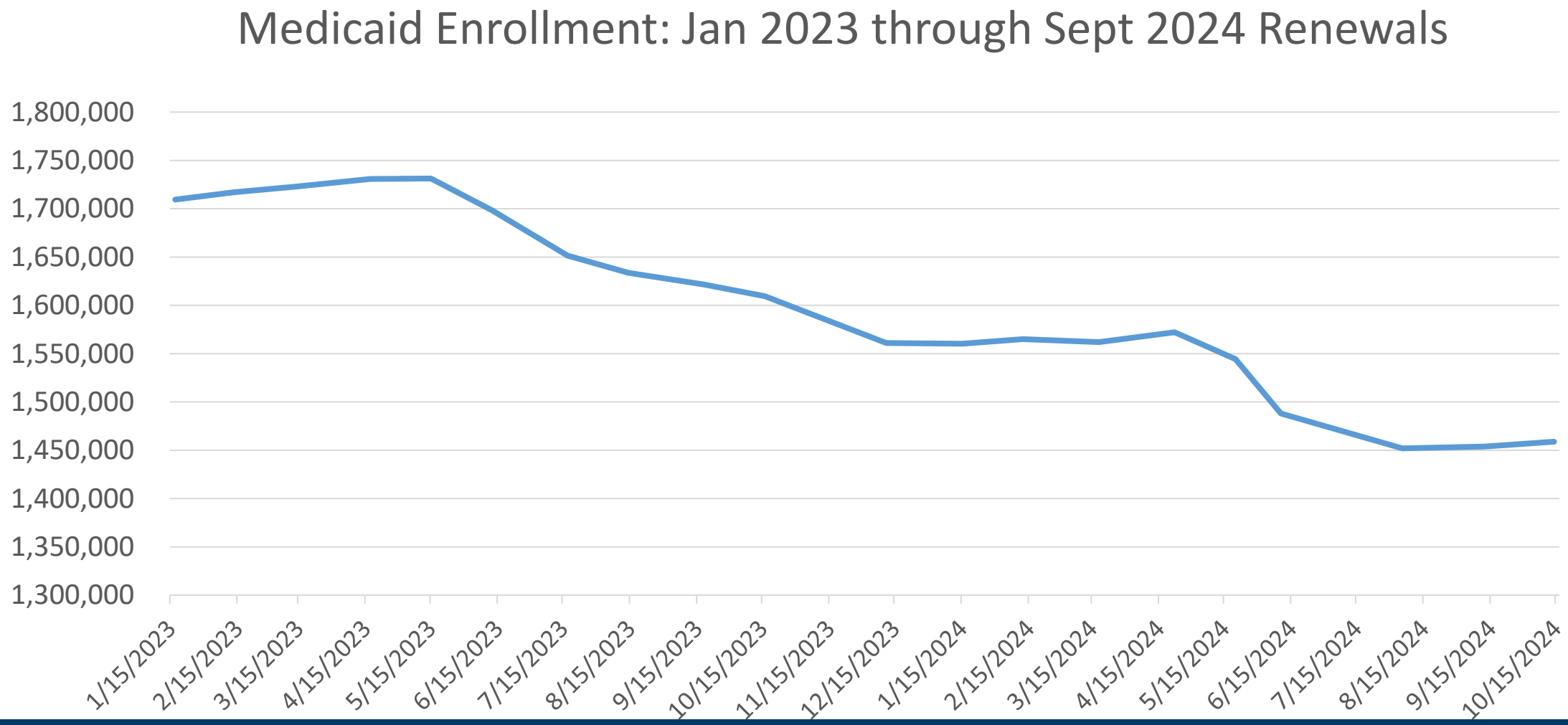
OFFICE OF THE COMMISSIONER

- Division of Quality & Population Health
- Division of Program Integrity
- Division of Long-Term Services & Supports
- Division of Fiscal Management
- Division of Health Care Policy
- Division of Health Plan Oversight
- Division of Information Systems

Kentucky Medicaid at a Glance

- Approximately 1.4 million members
- Over 600,000 children – more than half of the children in Kentucky
- 485,000 expansion members
- Over 69,000 enrolled providers
- $18.5 billion in total SFY 2024 expenditures (Administrative and Benefits combined)

Medicaid Enrollment Trend



Medicaid Benefits Budget

Benefits w/KCHIP (Dept 748)

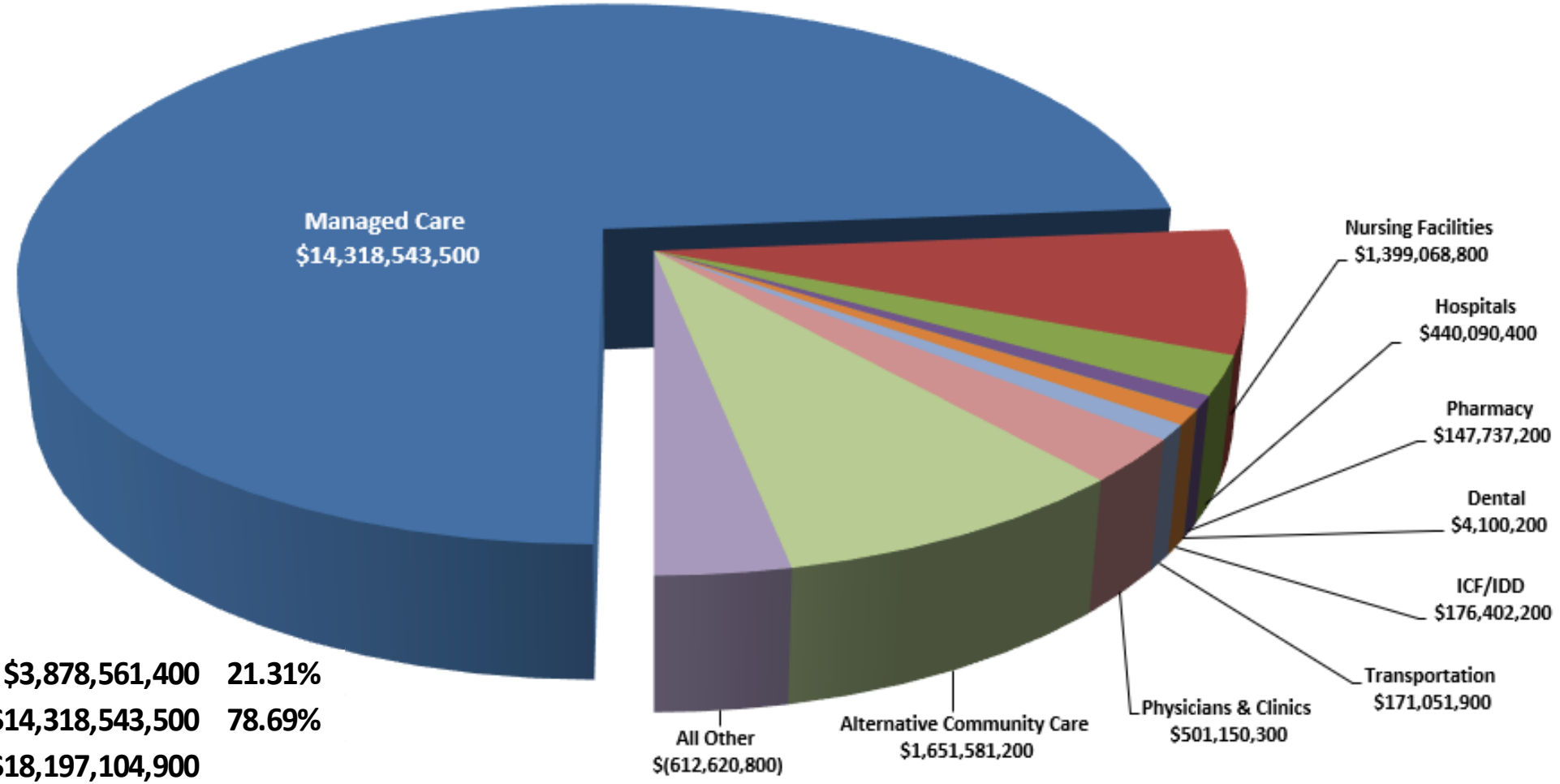
	SFY 2024 ACTUAL	SFY 2025 Budgeted
General Fund	$2,402,688,700	$2,563,029,800
Restricted Agency Funds	$1,537,488,100	$1,855,294,500
Federal Funds	$14,256,928,100	$14,747,533,400
TOTAL	$18,197,104,900	$19,165,857,700

Forecasting models were very successful for SFY 2024:

- Eligibility forecasts, including redeterminations, were within 0.45% of actuals.
- Actual expenditures were 0.41% lower than the projected expenditures.
- Agency funds on target for SFY 2025 expectations.

Medicaid Benefits

(Actual SFY 2024)



Total FFS:	**$3,878,561,400**	**21.31%**
Total MCO:	**$14,318,543,500**	**78.69%**
Grand Total:	**$18,197,104,900**	

Medicaid Benefits Budget

	SFY 2023	SFY 2024	Increase/Decrease	% change from 2023
Managed Care (MCO)	$ 13,001,486,400	$ 14,318,543,500	$ 1,317,057,100	10.13%
Non-Emergency Medical Transportation (NEMT)	$ 155,004,800	$ 162,737,100	$ 7,732,300	4.99%
Drug Rebate	$ (1,500,857,500)	$ (1,559,412,800)	$ (58,555,300)	3.90%
Fee-For-Service (FFS)	$ 4,920,472,900	$ 5,275,237,100	$ 354,764,200	7.21%
	$ 16,576,106,600	$ 18,197,104,900	$ 1,620,998,300	9.78%

- SFY 2024 expenditures increased by $1.62B (9.8%) over SFY 2023 expenditures.
- Approximately $233.7M (65.9%) of the FFS spending increase was due to an increase in waiver and nursing facility expenditures.
- The 10.13% increase in managed care payments is related to a $1.4B increase in State Directed Payments

Medicaid Benefits Budget

- Approximately 30.5% of the managed care payments are related to directed payments. The following are the SFY 2024 Directed Payments that totaled $4,366,289,200 paid in SFY 2024:

	SFY 2023	SFY 2024	Increase	% Change in SFY 2023
Hospital Rate Improvement Program (HRIP)	$1,362,928,400	$2,469,462,300	$1,106,533,900	81.2%
Abulance Provider Assessment Program (APAP)	$50,787,300	$56,548,800	$5,761,500	11.3%
University Directed Payment	$1,548,118,300	$1,840,378,100	$292,259,800	18.9%
	$2,961,834,000	$4,366,389,200	$1,404,555,200	47.4%

- This is expected to continue to grow in SFY 2025 due to SB280 and increase in average commercial rates

Medicaid Benefits Budget

	SFY 2023	SFY 2024	Increase/Decrease	% change from 2023
Supports for Community Living Waiver	$ 482,832,100	$ 505,683,200	$ 22,851,100	4.73%
Michelle P Waiver	$ 378,348,000	$ 415,669,300	$ 37,321,300	9.86%
HCB Waiver	$ 521,109,700	$ 605,514,400	$ 84,404,700	16.20%
Model Waiver	$ 1,737,700	$ 1,410,000	$ (327,700)	-18.86%
Brain Injury Waiver	$ 30,477,500	$ 34,403,200	$ 3,925,700	12.88%
ABI LTC Waiver	$ 40,428,500	$ 42,974,300	$ 2,545,800	6.30%
	$ 1,454,933,500	$ 1,605,654,400	$ 150,720,900	10.36%

- In aggregate, the six Medicaid Waiver programs experienced a $150.7M (10.4%) increase in total expenditures in SFY 2024 when compared to SFY 2023.

Anthem Transition Timeline

11/1/24
Anthem Notice of Termination

11/9/24
No new members except infants and no changes to Anthem

11/10/24
System Reassignment; Generate Member Notice

11/12/24
Mail Member and Provider Notices

12/31/24
Reinstatement to Anthem Ends

1/1/25
Reassignment Effective Date

Anthem Reassignment Plan

- Approximately 157,000 Anthem members automatically assigned to either Humana or United **resulting in an equal split** in the following order of priority:
  a. If a household member has the same MCO;
  b. If a preferred provider is in the network; or
  c. If not assigned in a or b above, then randomly auto-assigned in a round-robin fashion.
- System auto reassignment on **November 10, 2024** with an effective date of **January 1, 2025**
- Member reassignment notice mailed **November 12, 2024**

Anthem Reassignment Plan

- New and current members may no longer select or be assigned Anthem starting **November 9, 2024**
- Anthem reinstatements through **December 31, 2024** - member may select or be auto-assigned effective January 1, 2025
- An Anthem member choosing any MCO between **November 10 and December 31** overrides the automatic reassignment
- Another reassignment will occur at the end of December for any remaining Anthem members who were not reassigned on November
- DMS, Anthem, Humana and United will meet regularly to ensure smooth transition especially for members in care management, pregnant, inpatient, out of state, residential or ongoing treatment.

Anthem Transition Communications

- Member Written Reassignment Notice
- Provider Written Notice and Medicaid Partner Portal Email
- kynect and KYHealthNet Platform Announcement
- Anthem Member Self Service Portal and Worker Portal Posting
- Announcement distributed to Medicaid Advisory Council, Technical Advisory Committees, GovDelivery Emails, kynectors, insurance agents, provider associations and advocacy organizations
- Dedicated phone number for Anthem members - 1-833-501-9930
- Designated website, Kentucky Medicaid Anthem MCO Transition
- Frequently Asked Questions Document

Managed Care Organization Contract

- Base contract period January 1, 2021 to December 31, 2024
- There are six 2-year extensions
- Electing first 2-year option to extend until December 31, 2026 with Aetna (including Supporting Kentucky Youth), Humana, Passport by Molina, Wellcare and United
- Calendar year 2025 contract changes focused on clarifying current requirements and adding language for 1115 reentry and Consolidated Appropriations Act 2023 incarcerated youth requirements

Behavioral Health Provider Enrollment

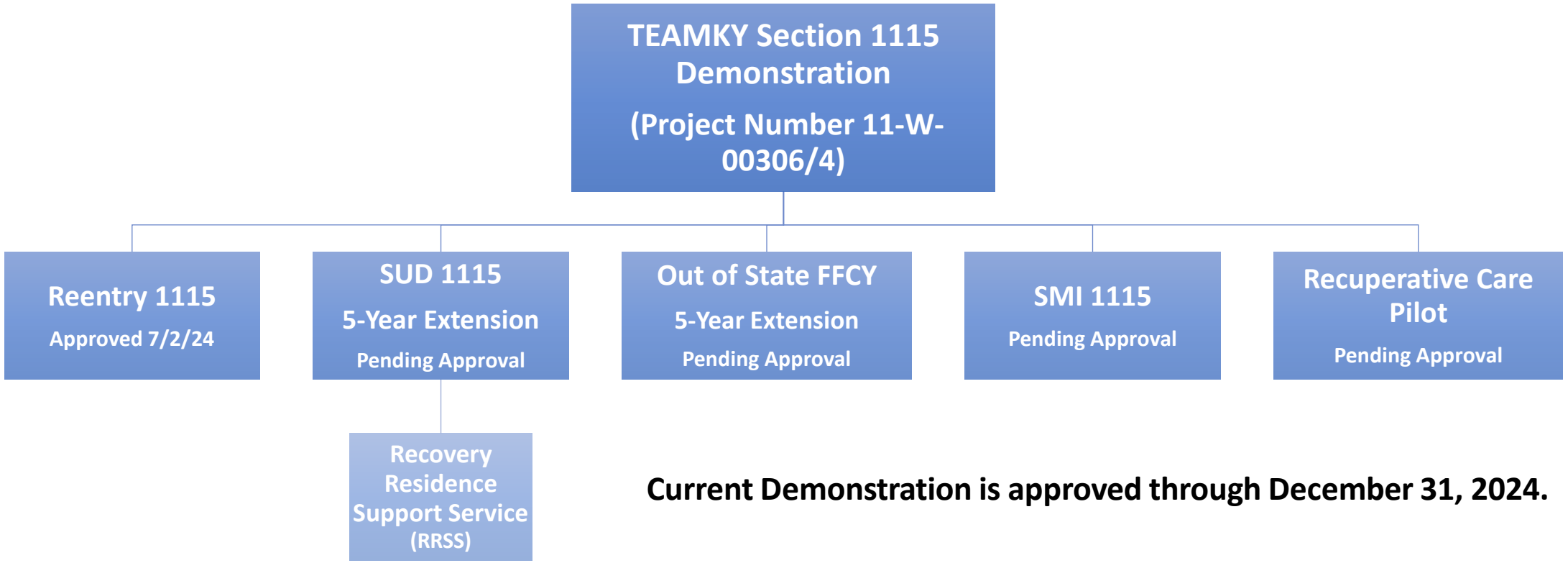
Provider Type	Distinct Provider Count
03 - Behavioral Health Service Organization (BHSO)	157
66 - Behavioral Health Multi Specialty Group	492
Grand Total	649

Behavioral Health

- Increase in behavioral health provider enrollment
- MCO program and policy changes related to behavioral health
  - Providers who were three standard deviations above peers in billing practice
  - Over 70% of billing was non-clinical
  - Outcomes were no better than peers
  - Readmissions and ER visits were continuing to increase
- Not all providers met this criteria
- Contract negotiations with providers who did meet the criteria

TEAM KY 1115 Components

Kentucky's Section 1115 Demonstration entitled "TEAMKY (formally known as Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH))" was approved January 2018.



Current Demonstration is approved through December 31, 2024.

Kentucky's Reentry 1115 Project

Incarcerated individuals and juvenile offenders are at higher risk for poor health outcomes, injury, and death than the general public.

Kentucky's Reentry Project was approved on July 2, 2024.

Medicaid will cover certain transitional services in state prisons and youth development centers, ensuring continuity of health care coverage pre- and post-release, and facilitating linkages to medical, behavioral health and health related social needs upon release.

Reentry Overview	
Eligible Populations	❖ All **adults** in one of Kentucky's **state prisons** (excluding state inmates housed in county jails) overseen by the Kentucky Department of Corrections (DOC). ❖ All adjudicated **youth** placed in one of Kentucky's **Youth Development Centers** (YDCs) overseen by the Kentucky Department of Juvenile Justice (DJJ).
Covered Services	❖ Case management to address physical health, behavioral health, and health-related social needs (HRSN) up to 60 days prior to release, and up to 12 months post-release. ❖ Medication-assisted treatment (MAT) with accompanying counseling for individuals diagnosed with a substance use disorder (SUD) up to 60 days prior to release. ❖ 30 Day supply of all medication (inclusive of over-the-counter [OTC] medications) as clinically appropriate, and if applicable, a prescription/written order for durable medical equipment (DME) immediately upon release.
Approved Settings	❖ Adult Institutions – State Prisons, DJJ - Youth Development Centers

Provisions of Medicaid Services for Placed Youth

The 2023 Consolidated Appropriations Act (CAA) includes Sections 5121 (**mandatory**) and 5122 (**optional**) that amend existing laws limiting Medicaid and CHIP coverage for incarcerated individuals.

Eligible Population

Section 5121

- Adjudicated juveniles under 21 years of age; **or**
- Between the ages of 18 and 26 if formerly in foster care.

Section 5122

- Pre-adjudicated juveniles under 21 years of age; **or**
- Between the ages of 18 and 26 if formerly in foster care.
- **Eligibility is not suspended**; individuals are entitled to benefits included under the approved service package.

Covered Services

Section 5121

- Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) screening and diagnostic services; includes medical, dental, and behavioral health; and
- Targeted Case Management 30 days pre-release and 30 days post-release.

Section 5122

- Allows states to request the full range of Medicaid/CHIP services the individual would otherwise be eligible for.

Approved Settings

- Youth Development Centers
- Youth Detention Centers
- State Prisons
- Local Jails

Source: CMS, "Overview: Sections 5121 and 5122 of the Consolidated Appropriations Act, 2023"

Reentry Project Timeline

Oct. 30, 2024

Submitted Implementation Plan to CMS

Nov. 29, 2024

Monitoring Protocol Due to CMS

Dec. 29, 2024

Reinvestment Plan Due to CMS

Dec. 29, 2024

Evaluation Design Due to CMS

Jan. 1, 2025

New youth Medicaid provisions effective

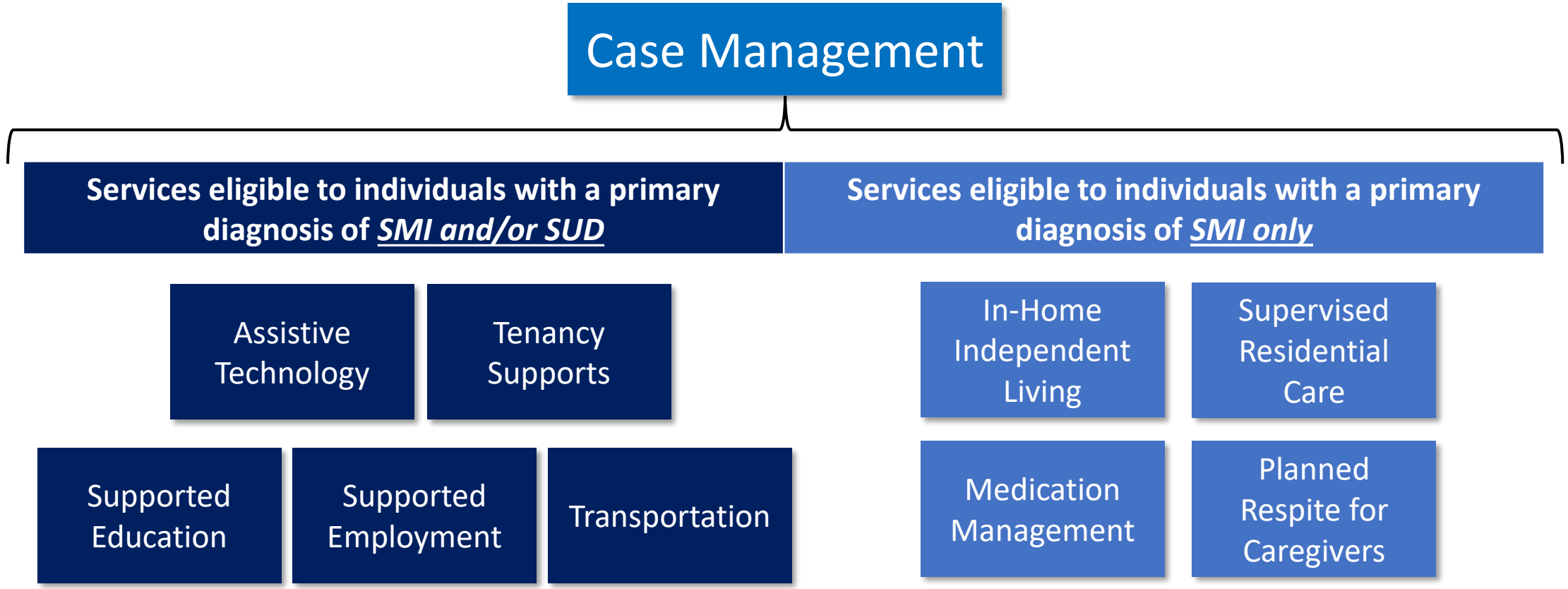
Oct. 1, 2025

Implementation upon CMS approval

SMI 1115 Demonstration Components

1. Reimburse medically necessary short-term, defined as a state-wide average length of stay no longer than 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness (SMI); DMS is referring to this component as **IMD Expansion.**
2. Implement a pilot program to provide Health-Related Social Needs (HRSN) services, specifically recuperative care services, also known as medical respite care, to adult beneficiaries who are homeless or at risk of homelessness and need additional medical support and care coordination. DMS is referring to this component as the **Recuperative Care Pilot Program**

What services will be included in the 1915(i) SPA?



1915(c) Home and Community Based Services (HCBS) Waivers

The Cabinet has submitted a proposed rate methodology to CMS and is negotiating pending rate updates to the 1915(c) HCBS waiver programs. There are several upcoming policy updates related to the HCBS waiver programs.

Rate Methodology Updates

- The Cabinet submitted six waiver amendments to CMS for review on October 1.
- The waiver amendments include a revised rate methodology for most HCBS services and associated service definition changes where applicable.
- The Cabinet received 217 public comments on the proposed amendments and posted the response to the DMS website on October 2.
- Waiver amendments have a proposed effective date of January 1, 2025.

Upcoming Policy Initiatives

- The Cabinet is currently in the process of drafting updated Kentucky Administrative Regulation that align with recent waiver renewals and amendments.
- The Cabinet anticipates American Rescue Plan Act (ARPA) Section 9817 funding will be spent in Winter 2024.
- The Home and Community Based Waiver and Model II Waiver are due for Federal renewal with CMS in 2025. The Cabinet has begun planning for renewal submission.
- The Cabinet has begun to develop new wait list management policies aligned with the assessment submitted to the General Assembly in October 2024.

1915(c) HCBS Waivers: State Fiscal Year (SFY) 2025 / 2026 Slot Allocation

The Cabinet is in the process of allocating the slots funded by the General Assembly and made available during SFY 2025 and 2026.

Waiver Program	Waiver Slots SFY 2024	New Slots in SFY 2025	New Slots in SFY 2026	Waiver Slots SFY 2026
1. Acquired Brain Injury (ABI)	383	0	0	383
2. Acquired Brain Injury Long Term Care (ABI-LTC)	438	+25 slots	+25 slots	488
3. Home and Community Based Waiver (HCB)	17,050	+250 slots	+500 slots	17,800
4. Michelle P. Waiver (MPW)	10,600	+250 slots	+500 slots	11,350
5. Model II Waiver (MIIW)	100	0	0	100
6. Supports for Community Living (SCL)	5,041	+125	+250 slots	5,416
Total	**33,412**	**+650 slots**	**+1,275 slots**	**35,537**

HCBS Waiver Wait List Management Assessment: Key Facts and Figures [1]

House Bill 6 requested DMS prepare and deliver an assessment of HCBS waiver program wait lists to the General Assembly by October 2024. The assessment found that many individuals on a HCBS waiver wait list can currently receive services through another Medicaid program.

Data Point	Data
Number of Individuals on a Waiver Wait List	12,847
Number of Individuals on More Than One Wait List	1,758
Percent of Individuals on a Wait List Who Have Access to Medicaid Services (e.g., Medicaid Managed Care, Fee-for-Service State Plan Services)	88%
Average Number of Weeks an Individual is on a Wait List (Across all HCBS Waivers)	171
Average Age of Individuals on a Wait List (Across all HCBS Waivers)	25.5 Years Old

Note: Data is as of June 30, 2024 to align with the data reflected in the 1915(c) Home and Community-Based Services Waiver Wait List Management Assessment delivered to the Legislative Research Commission on October 7, 2024.

HCBS Waiver Wait List Management Assessment: Recommendations

The Cabinet is implementing three recommendations to improve wait list management across the HCBS waiver programs. These recommendations will help the Cabinet comply with the Ensuring Access to Medicaid Services Final Rule by July 2027 (as Federally required).

Recommendation	Implementation Timeline
1. **Align Wait List Administrative Regulations and Policies Across Waivers:** The Cabinet will implement policy changes to confirm wait list management processes and requirements are aligned across all HCBS waiver programs and streamlined for waivers that share target populations.	**Oct. 2024 – Mar. 2027** (29 months)
2. **Standardize Waiver Application and Eligibility Review Process:** The Cabinet will enhance wait list information gathering processes to confirm waiver eligibility prior to placing individuals on the wait lists and allow for urgency of need review to prioritize slot allocation to individuals with the highest level of need.	**Oct. 2024 – Aug. 2026** (23 months)
3. **Modernize Wait List Management Data Collection Systems:** The Cabinet will integrate data collection and analysis into available tools to develop a publicly available wait list data dashboard. The dashboard will help the Cabinet deliver data driven updates to CMS, the Kentucky General Assembly, individuals on the wait lists, and other public stakeholders (e.g., advocacy groups). A dashboard will also help the State meet Federal Requirements per the Ensuring Access to Medicaid Services Final Rule.	**Oct. 2024 – Aug. 2026** (23 months)

Children Specific Waiver – Beginning SFY 2026

- Conduct Comprehensive System Assessment
- Conduct Service Mapping
- Gather documents and collect data
- Identify Stakeholders & Build Registry
- Develop Communication Plan
- Upcoming Advisory Workgroup – January 2025

Network Adequacy – University of Kentucky Research Project

- State University Partnership
- 2 year research projects
- 2024 first phase – project was 12 months rather than 24 due to delays in finalizing the contract
- Data issues mid-spring 2024 impacted ability to provide metrics in the final report
- 2026 continuation of project

Long Term Care 30 Day Eligibility

An individual must meet a nursing level of care (LOC) in order to receive long term care Medicaid coverage.

- DMS has an electronic and automated method of determining eligibility called the Kentucky Level of Care System (KLOCS).
- If an individual is determined eligible, the care received before LOC is determined is Medicaid covered through retroactive eligibility.

29

Long Term Care – Types of Beneficiaries

- Already Medicaid enrolled, in an MCO:
  - Patients in nursing homes could already be Medicaid recipients and be enrolled in a managed care organization (MCO).
  - **If the individual is in the nursing home for less than 30 days**, they will remain enrolled in the MCO, and the MCO will pay for all of the care.
  - **The individual stays in the nursing home for longer than 30 days. The individual is transferred to Fee-For-Service (FFS) Medicaid, and Medicaid is billed directly.**
    - The MCOs may be responsible for ancillary, physician, and pharmacy costs while the individual is being transferred to nursing home care. This shared responsibility is for 1-2 months while member transfers.
- Already Medicaid enrolled, in FFS:
  - The individual still must meet nursing LOC for Medicaid to reimburse.
  - Medicaid reimburses for all services provided.
- Individuals entering the Medicaid program for the first time as nursing home residents.
  - These individuals are assessed for LOC, and they begin and continue in Medicaid FFS. If LOC is eventually not met, the individual may then be enrolled in an MCO for the MCO to manage care.

30

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health and specialty services.
- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

EPSDT – CMS Guidance

- The Centers for Medicare & Medicaid Services (CMS) released guidance on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) on September 26, 2024. The guidance includes:
- Children and youth under 21 are entitled to coverage for all medically necessary preventive, diagnostic, and treatment services that are covered by Medicaid. This includes services that are optional for adults.

EPSDT – CMS Guidance (continued)

- Guidance on strategies to meet the behavioral health needs of children and youth, including creating a children's behavioral health benefit package.
  - New guidance supports maintenance therapy coverage.
  - If a provider network can't provide services, the contractor must cover them out of network at no more cost to the beneficiary than in network

QUESTIONS?